U.S. House of Representatives Veterans' Affairs Sub-Committee on Health

Making a Difference: Shattering Barriers to Effective Mental Health Care for Veterans

Nate Pelletier
Joseph House, Inc., Executive Director
Launch! Lab Innovations, LLC, Owner
West Point Society of Cincinnati, President

The Cincinnati VAMC is a best in class medical center; and, as a disabled Veteran, I've personally received outstanding care. As a Veteran leader, I have a vested interest in ensuring our federal and community resources enable all Warriors in transition and Veterans to successfully reintegrate. I've conducted research that studied the impact of transitioning Veterans and drafted a proposal[i] to assist not only the VHA, but the Departments of Defense, Labor, HUD and HHS[ii], as well as supporting agencies and community partners on how to improve and implement a sustainable transition system. As an Executive Director of a local agency supporting Veterans in need, I've witnessed what can happen if those who have served our country fall into the "gaps" of an inefficient transition and support network. On my very first day of work at the Joseph House, Inc., one of our War on Terror clients overdosed on heroin and nearly died in his room. Thankfully, his roommate was EMT certified and saved his life that day.

Over the next 3 years, more than 300,000 new Veterans will return to civilian society. Our communities need to be ready to serve them and utilize their talents in the community and in the workforce. To this end, there are two topics that are interconnected and deserving of this committee's attention- *VHA's scope expansion and VA administrative leadership's support for community partnerships.*

During the transition of new Veterans into the community, the VHA currently feels the burden to fill "gaps" in the process due to the absence of a seamless transitioning system. I define this as "scope creep". The DOD, VA (VBA/VHA), DOL, as well as other agencies and community organizations have acknowledged that the transition process is very inefficient and that the responsibilities of each organization are unclear. With this in mind, some examples of VHA scope creep include but are not limited to: employment assistance, education assistance, benefits assessment and family supportive services unrelated to medical services. As we attempt to define the responsibilities of the VHA during this process, we can categorize the decision making process into three groups - 1) processes that VHA funds and owns responsibility to execute, 2) processes that VHA funds

and outsources to community partners to execute, 3) processes that VHA outsources to community partners who are VA or privately funded and can own the responsibility to execute. In addition to addressing the systems and process responsibility to reduce scope creep, it is important for the VA administrative leadership to empower and leverage VHA and community partnerships.

In an attempt to fully assess the effectiveness of our VHA and recommend areas to partner with the community to reduce scope creep, we must define "what are the primary responsibilities of the VHA?" The purpose of the VHA is very focused and clear- support the medical needs of Veterans who qualify for medical services post military service. Any services in addition to their primary responsibilities should be assessed according to the three process categories mentioned previously.

The first step to effectively optimize the system of Veteran support is for the VA administration to take an active role in partnering and often time leading the convening of mobilized community action teams to collectively meet the needs of our Veterans. To quantify and provide some examples of how the VA administration could partner more effectively in Cincinnati in order to reduce scope creep, we can assess two areas of concern nationally and locally- employment and chemical dependency, as well as their potential relation to co-occurring mental health disorders.

Employment is a critical "node" that a Veteran must attain and sustain to successfully reintegrate (with the exception of those who are 100% disabled and unable to work). If this node collapses, it is most often the catalyst that dissolves secondary nodes within the ecosystem of support for a Veteran such as mental health stability (i.e. triggers PTSD symptoms- depression, self-esteem, sense of purpose, etc.) and can cause a Veteran to retract from social reintegration as well as lead to even further breakdowns in the ecosystem of support such as family relations, and sustainable housing. Too frequently, these breakdowns lead to the use of unhealthy coping mechanisms such as a reliance on drugs and alcohol. This is often the beginning of the "downward spiral" and collapse of a Veteran's sustainable reintegration. So where does the responsibility lie for disconnection in Veteran employment during the transition from Warrior to Veteran?

According to sources at the Joint Chief of Staff's Office for Warrior and Family Support, the DOD is accountable for more $960 million dollars in unemployment compensation to Veterans (unfortunately without the ability to fully evaluate their progress due to the fact Veteran's are no longer tracked in the DOD system post out-process).

However, more often than not, the VHA receives the primary burden of responsibility to assist unemployed Veterans given that they usually have the most access to the Veteran population in the region. This is an example of scope creep within our local VHA due to the inefficiencies related to "who owns what" in the transitional process from Warrior to Veteran. Therefore, the VA administration should emphasize the importance of engaging with the private sector and community partners who focus entirely on job placement. More often than not, this will be supported under category 3 mentioned above and secondarily, could reduce both the DOD and VHA scope creep.

Besides Veteran employment efforts, the VA administration can also optimize their VHA partnerships with the community agencies providing clinical treatment for Veterans with addictions. As the Executive Director of the Joseph House, Inc. for homeless Veterans with addictions, my clients are prime examples of the systematic breakdown of a Veteran's ecosystem of support. My clinical team has conservatively identified that 12 out of our 27 clients in our treatment program as of September 2013 have also been prescribed psychotropic medication for a co-occurring mental health disorder. It is important to note, that up to 78% or more of my senior clients (post-Vietnam) are suffering from co-occurring mental health and addiction disorders that are either unrelated to military service, possibly caused by socio-economic struggles, childhood adversity or other past experiences. However, a majority of our younger clients (War on Terror) are suffering from disorders related to PTSD, combat stress, and/or transitional anxiety in addition to these past experiences that have either led to chemical dependency or enhanced a pre-service addictive behavior. As it relates to our clients, mental health and chemical dependency are the primary nodes that have broken down within their ecosystem of support that likely caused their current state of homelessness.

Although the local VA administration has provided exceptional support through their VHA Community Outreach Division to fund and evaluate current programs like the Joseph House, Inc., it has been reluctant to support VHA participation in community-based Veteran mobilization efforts or “community action teams.” The VHA could optimize the impact of Veterans recovering from chemical addiction with effective engagement in both the housing and health sub-committees of the local Veteran community action team. VHA participation at an operational level will allow them to better assess funding support for community agencies according to the three process categories mentioned above. Furthermore, a more interactive relationship with community agencies will enable them to

share and assess best practices so that they can not only help improve the local agencies they currently fund, but their internal treatment program as well.

Local agencies such as the Joseph House, Inc., Talbert House Parkway Center, Volunteers of America to name a few in our region, provide services and treatment for Veterans suffering from homelessness and chemical dependency. The majority of our funding is provided through the VA Grant Per Diem program. Although the VA provides a series of measures to validate our funding each year, they also operate their own internal substance use program within the VAMC hospital. After reviewing their internal hospital program compared to local agencies, it is evident that they fund a higher percentage of staff treating a smaller percentage of Veterans compared to our external agencies. It is important to note that the qualifications and certifications per ODMHAS (Ohio Dept. of Mental Health and Addiction Services) for our cliental programs and staff are parity to the VAMC's program. Also, many of our clients have been referred to us from the VAMC hospital program due to negative discharges or time limitations of the program. Thus, a more collaborative partnership could potentially enable a more effective program match as soon as a Veteran is identified for treatment. Moreover, it is important to acknowledge the changing landscape in chemical addictions.

More Veterans, particularly the War on Terror Veterans are choosing opiates such as heroin vs. alcohol. It is important that we address the treatment options for opiate addiction vs. alcoholism and which programs are more qualified to provide treatment services - VHA or community agencies, or at minimum, create a stronger referral system between the two to ensure that the Veteran receives the proper care in a timely manner as soon as they are diagnosed. Recent studies have pointed out that, while substance use remains a key issue for Veterans, there has been a decline in specialized programs. Clients often respond better and stay engaged longer with specialized drug treatment programs. Therefore it is beneficial for the VHA and local agencies to partner to meet the treatment needs of new Veterans.[iii] This is why it is essential that the VA administration encourage their VHA teams to partner with the community in order to channel resources into one of the three process categories mentioned above, optimize internal and external treatment programs, and ensure that a Veteran is referred to the most relevant program to meet their treatment needs.

In summary, it is important to reiterate that the opportunities to optimize VHA scope creep and VA administrative leadership's support for community engagement are not

a reflection of the dedicated VA/VHA/VAMC leadership and staff, but the opportunity to optimize internal processes in order to sustain their primary responsibility of providing medical care for Veterans who qualify for benefits and treatment. To this end, it is the responsibility of all us who have "skin in the game" to operate more collaboratively to improve the transitional system and process of new Veteran reintegration and community efforts to sustain the well being of all our Veterans and their families.

In 2011, I received a call from the local VAMC at 10:30pm on a weekday to see if I could house a War on Terror Veteran for the night that had. Although he had just completed the chemical dependency program at the VAMC, he now had nowhere to go, no friends to call, no family to help and his time was up per the VA program guidelines. At around 11:30pm he arrived at my home, and for the next 2 hours he tearfully told me his story. Like many Soldiers, he signed up to serve his country, and suffered severe trauma related to combat that came home with him post deployment. If I recall correctly, his father had also recently passed away, and his mother was suffering from her own chemical dependency. Despite the breakdown of his support system, he "Soldiered on" and secured a meaningful job, but was later laid off like so many other Americans. Without stable housing or employment, he found solace on the streets and had built a relationship with local law enforcement to allow him to just spend a few nights on the street while he reached out for help during the day. And unfortunately like many homeless citizens in distress, he turned to alcohol as his coping mechanism. While he fortunately found his way to the VA where he completed their chemical dependency program, he did not have the support network to sustain his sobriety post treatment, and my home became his last resort that night. This story like so many others is simply unacceptable. We must think strategically, act operationally and continue to identify opportunities to improve the sytem while always keeping the end-state in mind- ensuring our Veterans thrive in our as productive members of our society. One Veteran left behind is one too many.

Endnotes:

---

[i] Clifford, P., Fischer, R. & Pelletier, N. (2013). Exploring Veteran disconnection: Using culturally responsive methods in the evaluation of Veterans Treatment Court services. Unpublished manuscript.

[ii] Pelletier, N. (2012). Successful Warrior to Successful Veteran. Cincinnati, OH: Author.

[iii] Eggleston, M., Straits-Tröster, K. & Kudler, H. (2009). Substance use treatment needs among recent Veterans. *North Carolina Medical Journal*, 70(1), 54-58.